Children's Mental Health Block Grant
FY 2006 – FY 2007

CRITERION 1: Comprehensive Community-Based Children's Mental Health Service Systems

The Children's Mental Health Bureau (CMHB) is part of the Department of Health and Human Services. Under the Health Resources Division (HRD), CMHB is responsible for management of children's mental health services and development of a system of care for youth mental health services. Established in July 2003 as a result of legislative action, CMHB is administered by the state of Montana with oversight by The Children's System of Care Committee and the Mental Health Oversight and Advisory Council.

CMHB staff includes a Bureau chief, a financial program officer, three clinical program officers, a field unit supervisor who is primarily responsible for the implementation of the SAMHSA grant, a data analysis/evaluator position, a media position and five (5) field program officers. With the exception of the field program officers, all staff are centrally located within the HRD.

Central office program officers are licensed clinicians responsible for oversight of specific Medicaid mental health programs: group care, youth case management, residential treatment, comprehensive school and community treatment (CSCT), etc. They provide budget management for these service areas resulting in cost containment. In addition, they provide clinical oversight to individual youth cases to field staff & are primarily responsible for court ordered youth. The field program officers are co-located in the regional Child and Family Services offices creating a structure that makes CMHB staff available across the state. The field staff are responsible for the development and implementation of the children's mental health system of care in each of five regions of the state. Their statewide presence increases the flexibility in facilitation, coordination, and planning of services to SED youth. They are also responsible for approval of CMHSP-Part B requests for supplemental services.

Children's Mental Health Bureau (CMHB) is responsible for management of mental health services from several funding sources: Medicaid, Children's Health Insurance Plan (CHIP) and the Children's Mental Health Service Plan (CMHSP). Children with serious emotional disturbance can access services by one of these plans. Each program has eligibility criteria and limits to their service array.

During the 2005 Legislative session the Montana Legislature changed Medicaid the eligibility resource test resulting in a projected additional 3000 youth will be eligible. The Children's Health Insurance Plan (CHIP) began increasing its enrollment July 1, 2005. Additional funding, due in large part to the tobacco tax increase, allowed CHIP to cover an additional 3000 children above the current enrollment of 10,900. Although CHIP remains a capped service, providing a limited number of slots, this increase eliminated the entire CHIP waiting list. CMHSP income guidelines are set at 150% of poverty. 135 youth are eligible for CMHSP- Part A if they are not eligible for Medicaid or CHIP.

Medicaid youth with SED have access to the following mental health services: inpatient psychiatric hospital care and partial hospital care, inpatient psychiatric residential care, therapeutic group and foster care, outpatient mental health services including assessment, individual & family therapy (limited to 24 visits per year), group therapy, school based day treatment, individual or group community-based psychiatric rehabilitation and support services, and targeted youth case management. Some services require prior authorization and periodic review for medical necessity.

Children's Health Insurance Plan (CHIP) covered youth with SED have access to limited mental health services-- Individual, family and group therapy (20 sessions per year), 21 days a year Residential treatment center, and unlimited pharmacy. The number of available slots caps this service is currently nearly 13,090 Montana youth.

The Bureau provides limited mental health services for individual who are within 150% of federal poverty guidelines under the program entitled Children's Mental Health Services Plan (CMHSP). CMHSP is 100% general fund and is a capped program at $671,982 for 2005. CMHSP- Part A includes the following services: community-based outpatient services of individual, group and family therapy, assessment and evaluation, psychotropic medication monitoring and management service, and mental health center services. CMHSP includes a psychotropic drug formulary up to $425 per month. CMHSP-Part B services are supplemental services directed at family preservation either by maintaining the youth in his/her family or returning the youth to parent's care. Part B services are not a covered service under the other above-named plans. Services include room and Board for therapeutic group care and foster care, 1:1 mental health aide services, family therapy, or other services to the family.

In September 2004, the Department of Public Health and Human Services was awarded a SAMHSA grant. Montana teams have been delegates to SAMHSA sponsored trainings during this first grant year. A Request for Proposals has been let seeking applications for four communities to receive awards of up to $185,000 for a maximum five years. The communities selected will be responsible for creating infrastructure for this system of care and will be provided flexible spending dollars designed to keep youth in their homes and communities.

The Department and the Office of Public Instruction collaboratively re instituted the Comprehensive School and Community Treatment (CSCT) program in 2004. The schools and mental health centers collaborate closely in determining the most appropriate and least restrictive services for those students with SED in the school system. These include day treatment and comprehensive school and community services. IDEA and the IEP play an important piece in this collaboration.

The Children's System of Care Committee (SOC's) ushered in a new approach to the delivery of services to youth with SED and their families. Created by the 2003 Legislature this advisory group continues to grow in its capacity to manage the emerging system of care, and provide leadership to local communities as Montana moves towards family & youth driven, community based mental health services. This new approach is guided by system values that include:

- Parent/Family participation is to be a part of all levels of the children's system of care from policy planning to participation in their child's treatment plan.

- The system is culturally competent requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- Providers, planning, policies, etc. focus on the strengths of the parents and family as contributors to treatment and recovery.
- "Top-Down-Bottom Up approach" in partnerships with local communities, including Tribes to design and develop the system of care.
- The system through partnerships with providers designs and delivers evidenced-based services to youth with SED and their families.
- Services for youth with SED will be co-occurring capable to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

Representatives from the following entities comprise the Committee:

- Parents and Youth
- Native Americans
- Office of Public Instruction
- Mental Health Advocates/Ombudsman
- Service Area Authority (SAA)
- Mental Health Oversight Advisory Council
- Department of Public Health and Human Services
  - Children's Mental Health Bureau
  - Chemical Dependency Program
  - Child and Family Services Division Disability Services Program
  - First Health Services of Montana
- Providers
- Supreme Court (juvenile probation)
- Legislature
- Department of Corrections

The KMA is the local community infrastructure that supports the comprehensive and statewide system of care. KMAs grew out of the Kids Integrated Delivery System (K.I.D.S. Project) that was developed and implemented by the Montana Children's Initiative Provider Association (MCI) in cooperation with DPHHS and the State Multi-agency Children's Committee. KMAs have two distinct and important functions:

- **Community Teams**

KMA Community Team representatives must have the authority to make decisions about and allocate money for services to youth and their families. They are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure unified and comprehensive service delivery, and serving as the gateway to the local system.

- **Individual Care Coordination Teams (ICCT)**

With few exceptions, parents are the leaders of the individual team for their child. The team is comprised of those agencies and individuals involved with the youth and their family. The team will design a unified and comprehensive treatment plan that encompasses all agencies serving an individual family. When the KMA is serving a Tribal youth, Tribal representatives have the opportunity to participate as full members in the KMA.

The gaps noted in Montana's systems of care continuum were very consistent and ranged from meeting the need for training and technical support on a variety of issues, to enhancing cultural

competence. Learning to braid categorical funding streams, bridging the chasms created by agency "lingo" and institutionalizing the use of consistent evaluation and assessment tools were also noted as priority needs. Finally, enhancing the working relationship between the state and local levels of the system of care was noted as a gap.

Some of the issues that Montana struggles with for youth include a: lack of clearly defined mechanisms for parental involvement, systems that fail to recognize and respond to early danger signs, inconsistent availability of community-based services, fragmented services, deficit-based views and a lack of cultural understanding.

Montana has a model in place for developing statewide infrastructure: the State Incentive Grant implemented the "Communities That Care" statewide. This project has received national attention for creating statewide prevention infrastructure. This model will be examined in building systems of care. Ultimately, the goal is to ensure better access to appropriate services for children and youth with SED and their families. In order to accommodate this, systems have to be aligned and working cooperatively at numerous levels. This will be the biggest challenge for Montana.

Two major goals for Human Resources Division are: to implement the systems of care philosophy at the state and local levels; and plan for, develop and/or enhance a wraparound process that will enable children with serious emotional disturbance and their families to access a broad array of supports and services necessary to meet their unique needs.

The philosophy of the public mental health system is to provide services that respect the preferences and rights of youth and family members as well as accommodate the special needs and circumstances of both. Montana's public mental health system strives to provide a full range of mental health services to children and adolescents with priority on services to youth with serious emotional disturbance. To the greatest extent possible, services are offered in the least restrictive, most appropriate, community-based setting, preferably in the adolescent or child's home

Montana currently has four community mental health centers that provide outpatient services in all fifty-six counties. In addition to these community mental health centers, Montana has thirteen licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center.

The Department contracts with six agencies to provide targeted youth case management. The providers are required to provide case management in identified service delivery areas (identified below with *). These contracts were competitively bid. Plans are to re-bid these contracts in 2006.

Eastern Montana Community Mental Health Center headquartered in Miles City - outpatient individual and group therapy; non-physician inpatient consultation; transitional living; telephone crisis services; consultation and education; and Department of Public Health and Human Services (DPHHS) approved chemical dependency services. Eastern Montana Community Mental Health Center provides services in the most eastern seventeen counties of Montana.

Golden Triangle Community Mental Health Center* headquartered in Great Falls - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; transitional living; telephone crisis services; consultation and education; youth

targeted case management; family based services; community psychiatric rehabilitation and support; and mobile crisis. GTCMHC serves a twelve county area in north central and southwest Montana.

South Central Regional Mental Health Center headquartered in Billings - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; telephone crisis services; consultation and education; and DPHHS approved chemical dependency services. South Central Regional Mental Health Center serves thirteen counties in south central and southwestern Montana. South Central contracts with Youth Dynamics to provide children mental health services.

Western Montana Community Mental Health Center* headquartered in Missoula - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; therapeutic foster care; Comprehensive School and Community Treatment (CSCT); therapeutic group home in Kalispell; telephone crisis services; mobile crisis worker services; consultation and education; youth targeted case management; community based psychiatric rehabilitation and support; and DPHHS approved chemical dependency. Western Montana Community Mental Health Center serves fourteen western counties in Montana.

Other mental health centers providing services to children and adolescents with serious emotional disturbance are the following:

AWARE* headquartered in Anaconda – provides respite care, therapeutic group homes, therapeutic family care, day treatment, Comprehensive School and Community Treatment; community based psychiatric rehabilitation and support, youth targeted case management, and in training practitioners. AWARE offices are located in over twenty-one communities.

Bitterroot Cooperative headquartered in Stevensville – provides Comprehensive School and Community Treatment; respite care and in training practitioners. Services are provided in six communities.

Kids Behavioral Health in Butte- provides residential treatment, outpatient, day treatment; Comprehensive School and Community Treatment; community based psychiatric rehabilitation and support services, and therapeutic group homes. Kids Behavioral Health provides services in nine communities.

In Care Network, Inc.* in Billings- provides community based psychiatric rehabilitation and support services; targeted youth case management; and therapeutic foster and group care, and upon request training on design and delivery of culturally sensitive services for Native American youth on the Northern Cheyenne and Crow reservations.

Intermountain Children's Home in Helena- provides therapeutic group home, therapeutic foster care, day treatment services, and outpatient psychiatric services (added in the summer of 2005).

New Day in Billings- provides therapeutic group home and day treatment services.

Yellowstone Boys and Girls Ranch* in Billings- provides respite care, day treatment, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic group home, therapeutic foster care, and youth targeted case management, and training for practitioners.

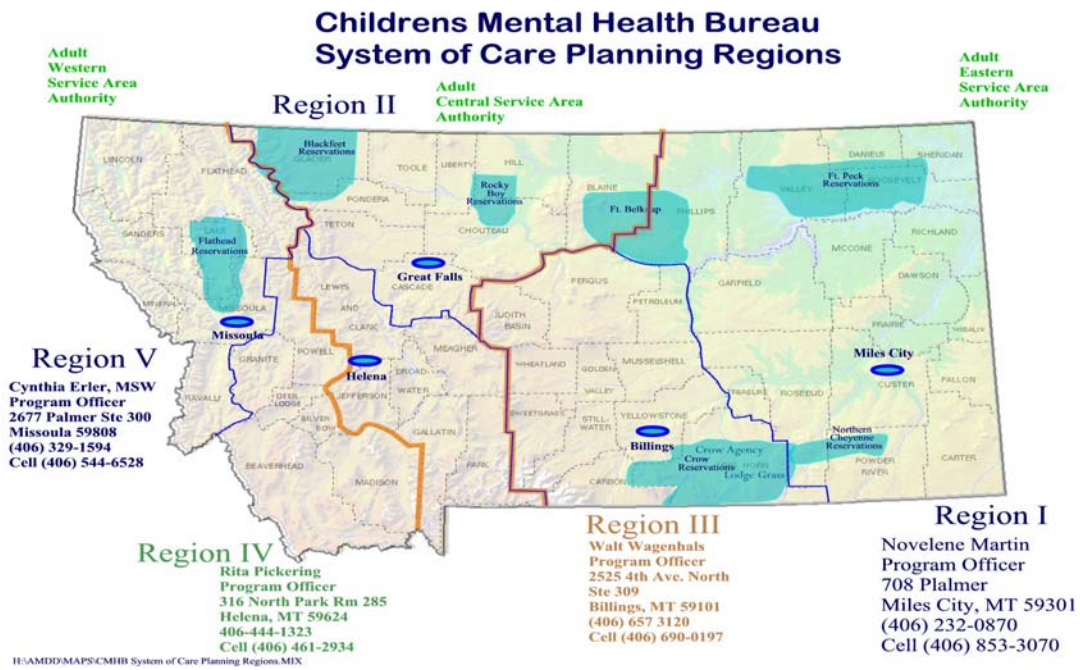
Youth Dynamics* headquartered in Billings – provides respite care, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic family care, therapeutic group homes, youth targeted case management, day treatment, and training for practitioners. Youth Dynamics provides services in twenty-four communities.

* indicates youth case management contractor

As of June 30, 2005 ACS had enrolled 58 psychiatrists (in state), 91 psychiatrists (out of state), 161 psychologists, 179 social workers, 422 licensed clinical professional counselors, 2 inpatient psychiatric hospitals (for individuals under 21), 3 in state residential treatment centers (RTC), 18 out of state (RTC), 14 therapeutic group home providers, 9 therapeutic foster care agencies, 210 pharmacies, 59 hospitals and 1,883 physicians in addition to the centers listed above.

Shodair provides in-patient psychiatric hospital services (under 21). St. Patrick's Hospital, Missoula; Kalispell Regional Medical Center, Kalispell; Deaconess Hospital, Billings; and Glendive Medical Center, Glendive provide limited inpatient psychiatric services for both children and adults.

The Department's utilization review contractor must authorize inpatient hospitalization. Prior authorization is also required for residential treatment, therapeutic family care and therapeutic group care. All remaining services are subject to retrospective review for medical necessity. In addition, the KMAs, regional care coordinators and the regional employees focus on community services and keeping the youth or adolescent in the community with services wrapped around the family.



Goal One: To transform the children's public mental health system to a recovery based system of care for children with serous emotional disturbance and their family.

Indicator One: 80% of the children with SED and their families who receive community-based mental health services and are surveyed will report their perception that they have been involved in their treatment planning.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions that relate to involvement of the respondents in treatment planning, on a five point response. Denominator: The total number of children and families respondents to the Consumer Satisfaction Survey.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Enhancement of youth and family participation in and responsibility for the planning and delivery of mental health services. Enhanced opportunity for preservation of family, increased feelings of being able to manage illness of SED, improved self-respect and reduced stigmatism.

Indicator Two: **To limit the percentage of inpatient psychiatric residential treatment facility placements in out-of-state facilities to 15% of all inpatient psychiatric residential treatment placements.**

Measure:	Numerator: The number of youth (unduplicated count) placed into out-of-state inpatient psychiatric residential facilities during SFY 2005. Denominator: The total number of youth under 18 years (unduplicated count) of age placed under Medicaid funding into inpatient psychiatric residential treatment during SFY 2005.
Source of Information:	Montana MMIS database.
Significance:	Delivery of out-of home services as close to the youth's family as possible enhances the opportunity for parent/family participation in treatment thereby improving opportunity for shorter lengths of care and return to the family at the earliest possible and appropriate time. Early return of the youth to the family reduces trauma impact of placement outside of the family, enhances self-esteem, and enhances parent/family involvement in treatment.
Indicator Three:	**Established a minimum of one Kid's Management Authorities (KMA) in each of the five Children's Mental Health management regions.**
Measured:	Employment of regional program officers in each of the five Children's Mental Health Bureau 5 management regions by October 2004. Establishment of at least 1 KMA in each region by September 30, 2005.
Source of Information:	Bureau FTE position report.
Significance:	Employment of regional program officer enables the Bureau to enhance efforts to established community-based multi-agency KMA's responsible for integration and coordination of development of the local community-based system of services, gathering of outcome data, and public education to reduce stigmatism of mental illness for youth and their families. Establishment of KMA's enhances the integration, coordination of service resources and funding among various agencies including school and youth court to ensure an integrated culturally appropriate treatment plan and service delivery for individual youth. Additionally, KMA development enhances opportunity for parents of SED youth involvement in development of the local system care, participation in decisions regarding system development, and their child's treatment plan and service delivery. KMA development also enhances the opportunity for coordination with the adult mental health system SAA effort, ensures parent participation in SAA, and transition services for youth approach the legal age of 18 and need to transition to the adult mental health system.

Indicator Four:	**65% of the children with SED and their families who receive services who receive case management services under Medicaid will report positively about their outcomes.**
Measure:	Numerator: The number of respondents who answer "Agree" or "Strongly Agree", to three survey questions relating to access, on a five point response. Denominator: The number of respondents to the survey.
Source of Information:	Statewide aggregated data from the Consumer Satisfaction Survey distributed through the Children's Mental Health Bureau six case management contractors to randomly selected families receiving case management services. Sample taken from the MMIS system for youth receiving case management services.
Significance:	Increased effective case management services allows parents to enhance self management skills, develop networking capacity, enhanced self-reliance and reduces stigmatism associated with having a family member who is SED. Effective case management also enhances the opportunity for school IEP's through supported parent efforts to appropriately address SED issues that interfere with education. Improved IEP's increase the opportunity for SED youth to remain in school and to achieve educational goals.
Indicator Five**:**	**Establish under the EPSDT screen program, early identification screen for children with mental illness.**
Measure:	Identification and inclusion within the primary EPSTD screen a mental health screen for children.
Source of Information:	Description of basis screens to be used as part of EPSTD screen conducted under the Medicaid program
Significance:	Early identification of mental health illness for youth, particularly youth under age 11 enhances opportunity for referral for further assessment and determination of illness as well as treatment needs. Early identification also enhances the opportunity for reducing the impact of the illness on the youth and the family, enhances opportunity for successful school experiences, enhances opportunity for mental illness to be seen as a health issue thereby reducing stigmatism for youth and families resulting form the mental illness.

CRITERION 2: Mental Health System Data Epidemiology

Descriptive Information:

The Department of Public Health and Human Services, Child and Adult Health Resources Division's Children's Mental Health Bureau using the serious emotional disturbance (SED) definition, applied a prevalence of 7% (based upon the CMHS methodology published in the July 17, 1998 Federal Notice) to the 2000 U.S. Census population data. When applied against Montana's children's population, aged 6 and above, the use of the 7% computes to a population of approximately 12,263 children with SED.

SED Definition:

"Serious emotional disturbance" (SED) means with respect to a youth between the ages of 6 and 17 years that the youth meets the requirements of (a), and either (b) or (c).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:
    (i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);
    (ii) oppositional defiant disorder (313.81);
    (iii) autistic disorder (299.00);
    (iv) pervasive developmental disorder not otherwise specified (299.80);
    (v) Asperger's disorder (299.80);
    (vi) separation anxiety disorder (309.21);
    (vii) reactive attachment disorder of infancy or early childhood (313.89);
    (viii) schizo affective disorder (295.70);
    (ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);
    (x) obsessive-compulsive disorder (300.3);
    (xi) dysthymic disorder (300.4);
    (xii) cyclothymic disorder (301.13);
    (xiii) generalized anxiety disorder (overanxious disorder) (300.02);
    (xiv) posttraumatic stress disorder (chronic) (309.81);
    (xv) dissociative identity disorder (300.14);
    (xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
    (xvii) anorexia nervosa (severe) (307.1);
    (xviii) bulimia nervosa (severe) (307.51);
    (xix) intermittent explosive disorder (312.34); and
    (xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

(b) As a result of the youth's diagnosis determined in (a) and for a period of at least 6 months, or for a predictable period over 6 months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;
(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;
(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;
(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;
(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or
(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous six months:
(i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;
(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;
(ii) the juvenile correctional system, due to the diagnosis determined in (a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or
(iii) current alcohol/drug abuse or addiction services as evidenced by participation in treatment though a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months or is predicted to continue for a period of at least 6 months, as manifested by one or more of the following:
(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;
(ii) atypical emotional responses, which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;
(iii) atypical thinking patterns which, considering age and developmental expectations are bizarre, violent or hypersexual;
(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction; indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers.

Goal 2:1: To provide medically necessary mental health services to eligible children and adolescents who have Serious Emotional Disturbance (SED).

Indicator**:** Maintain an array of community based services for children and adolescents with SED.

Children's Mental Health Services Plan Recipients by Service and Paid Claims

Services	FY 04 Individuals	FY 05 Individuals*	FY 04 Net Payments	FY 05 Net Payments*
Community Mental Health	2	9	$ 2,248	$ 24,535
Outpatient Hospital	0	0	$ 0	$ 0
Licensed Professional Counselors	81	103	$ 7,436	$ 9,254
Physicians	64	55	$ 4,445	$ 5137
Psychiatrists	8	12	$ 4,513	$ 4,182
Psychologists	4	1	$ 468	$ 51
Social Workers	4	0	$ 858	$ 0
Mid Level Practitioner	8	9	$ 652	$ 1,165
Respite	538	595	$ 307,825	$ 323,668

Medicaid Mental Health Services by Service and Paid Claims

Services	FY 04 Individuals	FY 05 Individuals*	FY 04 Net Payments	FY 05 Net Payments*
Community Mental Health	1783	2020	$ 3,821,560	$ 4,441,781
Inpatient Hospital	428	412	$ 2,848,874	$ 1,953,915
Licensed Professional Counselors	4191	4374	$ 2,345,306	$ 2,487,700
Physicians	3251	3302	$ 350,097	$ 368,973
Psychiatrists	2379	2279	$ 1,292,126	$ 1,106,647
Psychologists	897	979	$ 390,145	$ 423,618
Social Workers	1867	1949	$ 867,509	$ 949,313
Residential Treatment	441	452	$14,325,123	$14,392,332
Social Workers	1867	1949	$ 867,509	$ 949,313
Targeted Case Management	2951	3256	$ 3,835,007	$ 4,633,813
Therapeutic Foster Care	980	879	$ 5,144,221	$ 5,039,101
Therapeutic Group Care	531	531	$13,357,193	$14,609,237
School Based Services	968	6163	$ 2,509,333	$ 7,854,820
TOTAL	21,409	22,803	$52,962,324	$56,516,395

The following information affects the comparison of the cost analysis for mental health services. Effective May 2002, the mental health centers were required to enroll their psychologists, social workers and licensed professional counselors as separate. The expenditures for mental health centers

have decreased while the other provider types increased. Case management services are now provided through contracts with the mental health centers. All of the expenditures for these services may not be reflected. *Providers have 365 days to submit a claim for services rendered.

CRITERION 3: Children's Services

Descriptive Information:

The Department of Public Health and Human Services is utilizing the Kids Management Authority at the local level and System of Care at the state level to design and create the delivery of appropriate services including mental health and chemical dependency abuse services to children with SED and their families. The service delivery system is in its infancy and is making significant progress in developing a comprehensive integrated array of services. It is the intent of the department that all youth with SED receive appropriate and individualized care, in the most appropriate and least restrictive environment. Youth, parents, and families are the driving force in the individual treatment plan development and are equal partners in the KMA and SOC.

Collaboration exists at all levels of this system development from the SOC committee to the clinical program officers collaborating with their counter parts in other state agencies, to regional program officers collaborating in their local communities to increase community capacity and represent CMHB in individual treatment teams. State collaboration teams include but are not limited to the ECC, Connecting for Kids, CSCT (comprehensive school and community treatment), EPSDT (early periodic screening diagnosis and treatment), and Transition Work Group. State level personnel from Developmental Disabilities Division, Adult Mental Health, Child and Family services, First Health Inc., of Montana, Early Head Start Collaboration, Court Services, Department of Corrections, Tribal Nations.

Currently 18 communities across the state are in various stages of KMA development. Ten communities received state-funded grants to explore and develop a local KMA. Those sites are: Helena, Kalispell, Lewistown, Miles City, Great Falls, Bozeman, Cut Bank, Havre, Hamilton, Wolf Point. Other Montana communities actively engaging in KMA activities are: Butte, Polson, Missoula, Glendive, Billings, Crow Nation, Deer Lodge, Havre, Sydney, Glasgow, Salish and Kootenai Tribe, Sanders County, Mineral County, Ravalli County and very preliminary work is being done in Lincoln County. Field program officers are an integral force in each of these community teams.

The Department and the Office of Public Instruction collaboratively reinstituted the Comprehensive School and Community Treatment (CSCT) program. The schools and mental health centers collaborate closely in determining the most appropriate and least restrictive services for those students with SED in the school system. These include day treatment and comprehensive school and community services. IDEA and the IEP play an important role in this collaboration.

First Health, Inc. of Montana, utilization review contractor, has five regional care coordinators across the state to facilitate communication and cooperation among agencies and community services. The regional coordinators encourage the development of necessary services at the local level and are familiar with community resources and agencies. The coordinators encourage

communities and providers to develop local solutions rather than refer to residential facilities or out of state facilities. These coordinators team with Children's Mental Health Bureau field program officers to enhance the development and maintenance of multi-agency local community based treatment teams.

The SAMHSA grant requires participation in regional and national conferences related to system of care. Meetings in Dallas, Portland, Washington DC, and Indianapolis have afforded Montana team members to network and collaborate with existing system of care sites across the nation.

Goal 1, Indicator One: **Percentage of children with SED and their families who receive community-based mental health services including case management report that they have been involved in their treatment planning.**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	2003	2004	2005	2006	2007
Performance Indicator	89.5%	87.5%	87.8%	88%	88.1%
Numerator	111	65	65	66	67
Denominator	124	74	74	75	76

Indicator Two: Limit the percentage of inpatient psychiatric residential treatment facility placements in out-of-state facilities to 15% of all inpatient psychiatric residential treatment placements.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	8.7%	8.4%	8.4%	8.4%
Numerator	39	40	40	40
Denominator	446	477	477	477

Indicator Three: Children with SED and their families who received services including case management services under Medicaid will report positively about their outcomes.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	2003	2004	2005	2006	2007
Performance Indicator	64.1%	89.2%	89.3%	89.4%	89.6%
Numerator	91	66	67	68	69
Denominator	142	74	75	76	77

Goal 2, Indicator One: **Provide medically necessary mental health services to eligible children and adolescents who have Serious Emotional Disturbance (SED). Maintain an array of community based services for children and adolescents (youth) with SED.**

Measure: Numerator: number of youth recipients with SED receiving services by major service categories of residential services, assessment, individual-group-family therapy, targeted case management, therapeutic group and foster care, youth receiving comprehensive school and community treatment, community-based psychiatric rehabilitation and support services (individual and group combined), and partial hospitalization in SFY 2005.
Comparison: The number receiving same services in SFY 2004.

Source of Information: MMIS system reporting Medicaid claims paid.

Significance: Reporting of unduplicated counts of clients served and dollar amounts demonstrates maintenance of the system of care.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Community Based				
Assessment	$ 655,345	$ 704,241	$ 704,241	$ 704,241
Individual thx	$ 2,309,769	$2,337,081	$2,337,081	$2,337,081
Group thx	$ 89,228	$ 90,534	$ 90,534	$ 90,534
Family thx	$ 771,127	$ 906,020	$ 906,020	$ 906,020
Respite	$ 357,354	$ 356,305	$ 356,305	$ 356,305
Comprehensive School & Community Tx	$ 4,370,099	$5,687,509	$5,687,509	$5,687,509
Day Treatment	$ 1,088,499	$1,438,114	$1,438,114	$1,438,114
Psychiatric rehabilitation & support	$ 2,437,811	$3,227,102	$3,227,102	$3,227,102
Targeted Case Management	$ 3,835,008	$4,635,457	$4,635,457	$4,635,457
Out of Home				
Therapeutic Foster Care	$5,140,370.76	$5,039,102	$5,039,102	$5,039,102
Therapeutic Group Care	$13,342,896	$14,609,237	$14,609,237	$14,609,237
Psychiatric Hospitalization	$ 4,479,138	$ 3,550,051	$ 3,550,051	$ 3,550,051
Inpatient Psychiatric Residential	$14,296,097	$14,392,332	$14,392,332	$14,392,332

Treatment				

Indicator Two: Maintain the average length of stay in inpatient psychiatric residential care (RTC) at less than 6 months (180 days)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	152.8 days	160.0 days	160.0 days	160.0 days
Numerator	40794	48060	48060	48060
Denominator	267	267*	267*	267*

*Estimated numbers.

Indicator Three: Children with SED and their families who receive community-based mental health services and are surveyed will report a positive perception of access to services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	2003	2004	2005	2006	2007
Performance Indicator	72.5%	83.8%	84%	84%	84.4%
Numerator	103	62	63	64	65
Denominator	142	74	75	76	77

Indicator Four: Children with SED and their families who receive community-based services including targeted case management services will report a high cultural sensitivity of staff delivering services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	2003	2004	2005	2006	2007
Performance Indicator	94.4%	85.1%	85.3%	85.5%	85.7%
Numerator	117	63	64	65	66
Denominator	124	74	75	76	77

Indicator Five: Eligible youth will access mental health services.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	20%	18.0%	18.0%	18.0%
Numerator	9208	8008	8008	8008
Denominator	44,492	44,492*	44,492*	44,492*

*Estimated number.

Indicator Six: Montana youth under 18 years of age will access mental health services.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	4.0%	3.6%	3.7%	3.8%
Numerator	9208	8282	8512	8742
Denominator	230,062*	230,062*	230,062*	230,062*

*Reported by U.S. Census 2000

Goal Three: **Integrate services for children and adolescents with Serious Emotional Disturbance who impact multiple agencies in the community.**

Indicator One: **The System of Care (SOC) committee will meet a minimum of eight times during SFY 2006 to assist the Department in provision of training communities to develop local KMA's, identify issues and solutions, and facilitate coordination of multiple agencies resources.**

Measure: Committee meets 8 times during SFY 2006.

Source of Information: Minutes from the SOC's committee meetings.

Indicator Two**:** Maintain contract requirement for agreement between mental health provider and the substance abuse provider.

Measure: State approved chemical dependency programs under contract with the Department's AMDD Chemical Dependency Bureau continue to maintain contracts with mental health providers for provision of services to individual co-occurring illness of substance dependency/abuse and mental illness.

Source of Information: Chemical Dependency Bureau contract with provider.

Indicator Three**:** Development of a minimum of one additional KMA in each Children's Mental Health Bureau geographic management region for field staff in SFY 2006.

Measure: One KMA developed in each region reported by program officer to SOC's committee.

Indicator Four: Provision of technical assistance to communities directed at the development of KMA's at the local level.

Measure:	Provision of at least one conference/training session for communities on system of care, KMA model, and benefits of a community KMA.
Indicator Five**:**	Complete review of therapeutic group care service including licensure requirements, population served, population needing to be served, reimbursement rate, co-occurring capable readiness and other related issues.
Measure:	Task forced established, meets as needed to complete tasks assigned, and provides recommendations to the Department Children's Mental Health Bureau.
Indicator Six:	**Maintain the average length of stay in inpatient psychiatric residential care (RTC) at less than 6 months (180 days).**
Measure:	The average number of days in inpatient psychiatric residential care for all youth discharged from RTC in SFY 2005. Numerator: total number of days of RTC paid by Medicaid for youth receiving RTC in 2005. Denominator: Total number of youth receiving RTC in SFY 2005.
Source of Information:	MMIS Medicaid payment information system.
Significance:	The longer a youth is out of the community/home, the greater the risk the youth will remain out of the home. Shorter lengths of stay in RTC a one indicator of community-based service efforts to step youth with SED done to less restrictive and intensive level of care at the earliest appropriate opportunity.
Indicator Seven:	**75% of children with SED and their families who receive community-based mental health services and are surveyed will report a positive perception of access to services.**
Measure:	Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions that relate to involvement of the respondents to access on a five point response. Denominator: The total number of children and family respondents to the Consumer Satisfaction Survey.
Source of Information:	Statewide aggregate data from the Consumer Satisfaction Survey.
Significance:	Timely access to community-based service reduces risk of out-of-home placement, school drop out, and collateral impact of serious emotional disturbance for the child and the family.

Indicator Eight**:**	**95% of children with SED and their families who receive community-based targeted case management services will report a high cultural sensitivity of staff delivering service.**
Measured:	Numerator: number of respondents to answered "Agree" or "Strongly Agree" to three survey questions that relate to involvement of the respondents to access on a five point response. Denominator: The total number of children and family respondents to the Consumer Satisfaction Survey.
Source of Information:	Statewide aggregate data from the Consumer Satisfaction Survey.
Significance:	Provision of culturally sensitive services enhances the opportunity for successful treatment of the SED youth and preservation of the family unit.
Indicator Nine:	**20% of eligible youth will access mental health services.**
Measured:	Numerator: unduplicated number of youth served under Medicaid Mental Health service plan in SFY 2005. Denominator: The total number of children determined eligible for Medicaid for the SYF 2005.
Source of Information:	MMIS Medicaid payment information system for number served. TEAMS information system for number of youth determined eligible for Medicaid.
Significance:	Information is one indicator of impact of inclusion of mental health screen within EPSTD basic screen.
Indicator Ten**:**	**4% of all Montana youth under 18 years of age will access mental health services.**
Measured:	Numerator: unduplicated number of youth served under Medicaid Mental Health service plan in SFY 2005. Denominator: The total number of youth under the age of 18 in U.S. Census for 2000.
Source of Information:	U.S. census data reported for Montana. MMIS payment information system for Medicaid services.
Significance:	Reporting this information over time is an indicator of level of penetration for services and in part assist in determining success of early identification of mental health illness resulting from inclusion of mental health screen as part of the basic EPSTD screen conducted in Montana.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Descriptive Information:

Montana has three communities, which meet the U.S. Census Bureau definition of "urbanized areas." Those communities are Billings (2000 census population of 89,847), Missoula (2000 census population of 57,053), and Great Falls (2000 census population of 56,690). On the other hand, 45 of Montana's 56 counties meet the Bureau of Health Care delivery and Assistance definition of "frontier" by having a population density of fewer than six people per square mile. 32% of the state's population resides in frontier counties. The overall population density of Montana is 6.2 people per square mile.

Indicator One**:**	Provision of outreach services to persons who are homeless and have a mental illness through the PATH grant using the AMDD contract requirement.
Measure:	Numerator: Number of youth identified by PATH who are referred and receive mental health services. Denominator: Total number of youth identified by PATH who need mental health service.
Source of Information:	AMDD database for PATH services.
Indicator Two**:**	Provision of services to youth with SED who are under the custody of the Department's Child and Family Services (CFS) because of neglect and/or abuse, in out-of-home placements and require mental health services.
Measure:	Numerator: Number of youth who are under custody of CFS receiving mental health services in SFY 2005. Denominator: Total number of youth receiving mental health services in SFY 2005.
Source of Information:	MMIS Medicaid payment information. Child and Adult Protective Services (CAPS).

CRITERION 5: Management Systems

Descriptive Information:

Efforts to attract qualified professionals to work in Montana's public mental health system are continuing. A practicum in psychiatric nursing at the State Hospital is available for nursing students, as are internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, CMHCs provide opportunities for the establishment of student field placements and in training practitioners. These experiences are aimed at helping future professionals

understand the needs of persons with severe and disabling mental illness and the unique satisfaction that comes from working in the public mental health system. Taking advantage of loan forgiveness incentives associated with working in Health Professional Shortage Areas also assists in recruitment. Montana has only a small percentage of psychiatrists taking advantage of this program. APRNs are allowed to prescribe medications, which have taken a load off of the need for psychiatrists.

The Department continues to be actively involved in advancing education and training opportunities relating to the implementation of a community-based system of services. Many consumers, family members, advocates, and professionals working in the system attend these programs. These efforts encourage cooperation and coordination of services among the many different components of the State's mental health system.

The block grant is not used to support children's mental health services as legislative decision resulted in the limited amount of block grant being used to support adult mental health services. TANF (Temporary Assistance for Needy Families) maintenance of effort funds (state general funds) in the amount of $671,928 are used to fund the limited Children's Mental Health Service Plan (CMHSP). These funds are used to purchase community-based services for children and adolescents with SED. The Children's Mental Health Bureau staff work closely with the CHIP staff to determine eligibility for the CMHSP program and to identify youth who need mental health services. Additionally part B of the program provides supplemental mental health services to youth in group homes, fosters care along with family services to enhance the opportunity for the child to return home or to step down to a less restrictive treatment environment. The primary components of community-based treatment include identification (assessment) and referral, outpatient services, psychotropic medication, and family support services such as respite and home based services.

Goal 5:1 **To offer training at a community level to emergency services personnel.**

Indicator**:** Training will be offered to Emergency Medical Services, Sheriffs and Peace Officers.

Indicator**:** Meet with the Law Enforcement Academy to include information on serious emotional disturbance to new cadets.

Indicator**:** Discuss potential training opportunities with juvenile justice personnel.

Goal 5:2 **To ensure consumer and family member participation.**

Indicator**:** Maintain a minimum of 50% consumer and family members on the Mental Health Oversight Advisory Council. (MHOAC).

Indicator**:** Continue to educate Local Advisory Councils (LAC) members in partnership building in the regional planning process.

Indicator**:** Have regular contact with the Mental Health Ombudsman Office.

Indicator**:** Actively participates in regional planning.

Goal 5:3 **To offer education to family members.**

Indicator**:** Contract with NAMI to provide a teacher training of the Family-to-Family program to a minimum of four individuals.

Indicator**:** Offer Family-to-Family education program in a minimum of three communities.

Indicator**:** Explore the feasibility of offering training over a weekend for those rural communities.

Indicator**:** Children's System of Care and Kids Management Authority provide the conduit to Technical Assistance Partnerships (TA Partnerships) for appropriate training and support.

Goal 5:4 **To encourage provider training.**

Indicator**:** Contract with NAMI for provider training.

Indicator**:** Provide support to Mental Illness Conference.

Indicator**:** KMA's provide the conduit to TA Partnerships for appropriate training and support.

Goal 5:5 **Continue the children's set aside for youth and adolescent services.**

Indicator**:** A total of $671,928 TANF Maintenance of Effort will be expended for approved services.

*Estimated numbers.